Summit Healthcare will use the information provided by the employee’s physician to help in determining the patient’s work status. Thoughtful consideration in completing this form will, therefore, be greatly appreciated.

<table>
<thead>
<tr>
<th>Today’s Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Name:</td>
</tr>
<tr>
<td>Date of Injury/Illness or Condition:</td>
</tr>
</tbody>
</table>

**CARE PROVIDED:**

- [ ] Surgical
- [ ] Interventional Treatment
- [ ] Physical Therapy – Frequency/Duration

- [ ] Other

**Medication:**

Please list medications associated with this event that could have a negative effect on their physical or mental abilities to perform the duties of the attached job description.

- [ ] Avoid Driving or Operating Machinery While Using This Medication.
ASSESSMENT OF PATIENT ABILITY TO PERFORM CURRENT JOB:

Attached is a copy of the Job Description for this position.

Can the patient currently be reasonably expected to perform the listed activities without being placed at risk or create patient risk due to their medical or physical condition? Please initial applicable response(s) and provide appropriate comments.

_________ YES, the employee can perform the current job duties without any restrictions.

_________ YES, if the following conditions listed below can be met:

Please list the conditions:

________________________________________________________________________

________________________________________________________________________

________ NO, the employee cannot currently be reasonably expected to perform the listed activities without being placed at risk.

Please indicate reason(s) and explain:

________________________________________________________________________

________________________________________________________________________

If you answered “No” to the previous question, do you expect a fundamental or marked change in the future?

Please initial appropriate response(s) and provide appropriate comments.

________ NO. If “no” please explain

________________________________________________________________________

________________________________________________________________________

________ YES.

If “yes” please indicate when you feel the patient will recover sufficiently to perform duties

________________________________________________________________________

________________________________________________________________________

WORK STATUS:

☐ Return to regular work on (please specify date):

________________________________________

☐ Unable to work until (please specify date):

________________________________________

☐ Return to transitional duty on : __ for ___ days with the restrictions noted above.

________________________________________
FOLLOW-UP CARE:

☐ Estimated length of treatment: ________________________________
   □ Days □ Weeks □ Months

☐ Scheduled for physician appointment on date: ________________________________

☐ Scheduled for physical therapy on date: ________________________________

☐ Referral: ________________________________

☐ Discharged from care, stationary, with _____% impairment of ________________________________

SIGNATURE

Thank you for your assistance. If you have any questions, please contact Connie Kakavas, Chief
Human Resources Officer, (928) 537-6366

Physician Name: ____________________________________________
   (Please Print or Type)

   Physician Signature: _______________________________________

Address: ___________________________________________________
   ___________________________________________________
   ___________________________________________________

Phone number: ____________________________________________

Facsimile number: ____________________________________________